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Why the views of middle class citizens help explain increased choice in European healthcare systems

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Several countries across Europe have attempted to reform their health systems by allowing patients more choice over their healthcare provider. The typical rationale for this strategy is that by creating

*competition between providers, there will be an increased incentive to improve the efficiency and quality of healthcare. **Joan Costa-i-Font** and **Valentina Zigante** assess the underlying factors that have led to European countries adopting this ‘choice agenda’ in their healthcare systems. They find that one of the key drivers for this type of reform has been the role of middle class citizens in demanding greater choice over health providers.*

A key tenet of European health and consumer protection strategy lies in

consistent with that goal is that of **furtherring provider choice**, which does not always encompass widening financing choice, often referred to as the ‘choice agenda’.

For a patient to benefit from choice, health systems need to widen their service diversity, which from a provider perspective entails the introduction of some level of competition in the organisation of public

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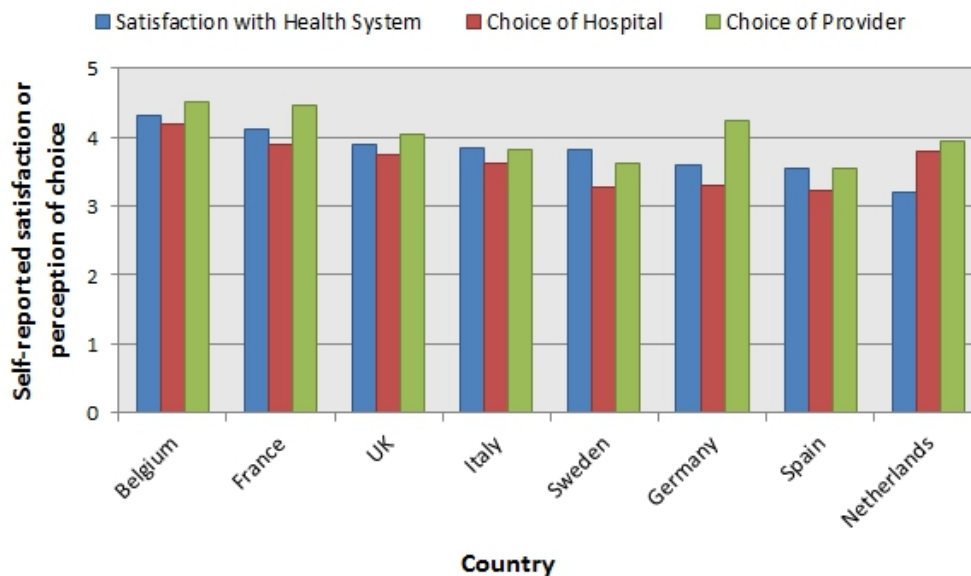
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services. A textbook explanation for the benefits of such a reform would go as follows: the empowerment of potential choices rewards provider performance which incentivises more efficient production and improved quality at the expense of ‘consumerism’ governing the relation between patients and providers. The Chart below shows self-reported perception of the choice available in selected European healthcare systems and the level of satisfaction citizens report in the healthcare system overall.

Chart: Mean rating of citizens’ perceived ‘freedom to choose’ in selected European countries and citizens’ overall satisfaction with their health system



Note: The chart shows an estimation of the mean rating by citizens of their freedom to choose a hospital or a healthcare provider based on responses to the 2002 [World Health Survey](#) (using a numerical scale in which the higher the rating the more perceived choice there is). The chart also shows the mean level of satisfaction with health systems in each country using the same numerical scale. There is a weak but positive correlation between citizens’ satisfaction with the health system and their perceived ability to choose their provider (i.e. countries with higher levels of perceived choice also have higher levels of satisfaction).

In a [recent article](#) we assess the political economy arguments, such as the modernisation of the health system and middle class aspirations. The latter departs from a well-established body of literature on the demands of the middle-class driving the public policy agenda dating back to Robert Goodin and Julian Le Grand’s book, *Not only the poor: the middle classes and the welfare state*.

Why have European countries embraced the ‘choice agenda’?

The first potential ‘driver’ of the European choice agenda is a



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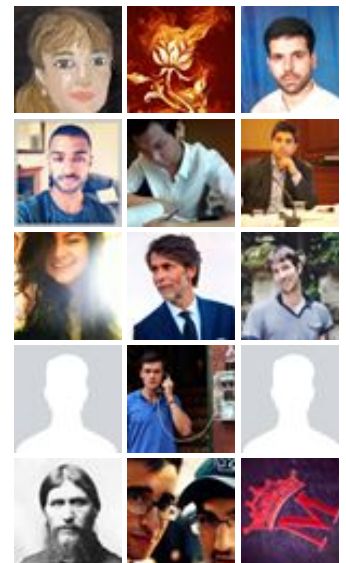
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preoccupation with improving efficiency. In its core principles, the choice agenda seeks to empower citizens as fictitious market consumers. However, unlike in a free market, provider choice and competition in health systems enacts a set of more complex mechanisms limited by two principles in particular. Although choice can act as an implicit (public) price, unlike in a market system, tax connections are complex to establish. More importantly, consumers' capacity for judging health care quality tends to be poor. This implies that the efficiency argument is probably insufficient to justify the choice agenda, even when **evidence** shows its importance.

Second, the choice agenda can be argued to result in *provider capture*; that is, the potential for providers to increase their rents at the expense of the rest of the health system. This argument is consistent with evidence of the increasing role of private providers in advocating choice reforms. However, provider choice does not necessarily involve a drastic expansion of private providers. Instead it might result in the strengthening of more efficiently run public providers. Evidence suggests that the role of private options varies considerably between the countries within our sample and is intertwined with auxiliary sectors such as the pharmaceutical industry.

Third, several countries have moved towards choice and competition reforms following a reaction to shortcomings in their health care systems. Examples of shortcomings include excessive waiting times, the lack of a patient-centred approach, and overly bureaucratic procedures. Again, however, quality alone does not seem to explain the spread of the 'choice agenda' across different countries.

Finally, the middle class within European countries could be argued to have a distinct preference for consumer choice. They also **stand to benefit** substantially from universally provided services and benefits, at times even more so than other social groups, due to their ability to manoeuvre the system as a result of their generally higher levels of education and societal standing (e.g. connections).

Supporting this argument, our evidence revealed a link between the availability of provider choice and individual satisfaction with the health care system, which was particularly noticeable among middle range income groups in tax funded (NHS) countries. The role of choice is however less noticeable in Italy and Spain, given that middle class

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citizens in these countries tend to purchase complementary private health insurance instead of relying exclusively on the NHS offer. Overall, our research is consistent with the argument that middle class demands for healthcare choice are a key driving force in determining models of care.

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Note: This article gives the views of the authors, and not the position of EUROPP – European Politics and Policy, nor of the London School of Economics. Featured image credit: [George Dowle](#) (CC-BY-SA-3.0)

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